VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
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February 12, 2013

Ms. Marcia Derosia, Administrator
Our Lady Of Providence
47 West Spring Street
Winooski, VT 05404

Provider #: 0198

Dear Ms. Derosia:

Enclosed is a copy of your acceptable plans of correction for the survey and complaint investigation conducted on **January 11, 2013.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

PC:ne

Enclosure

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0198	A. BUILDING _____ B. WING _____	C 01/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF PROVIDENCE	47 WEST SPRING STREET WINOOSKI, VT 05404

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R100	Initial Comments: An unannounced on-site complaint investigation was initiated by the Division of Licensing and Protection on 01/09/13 and completed on 1/11/13. The following are Residential Care Home regulatory findings.	R100	**R145 The facility hired a Health Systems Coordinator starting January 2, 2013 to work with the DNS and nursing department to evaluate the current record system and system flow and implement documentation changes to assure compliance with regulation and standards of care practice. A full chart audit will be completed to determine that the deficient practice has not recurred. 3/31/13** **A new 24 Hour Report of Resident Change in Condition form is being utilized which includes a grid for Change in Condition, Narrative, Event Reporting and Follow-up. The Director of Nursing is responsible to audit the 24 Hour Change Report to the resident records and follow-up for accountability of nursing overview, administration of medication, and nursing care. Follow-up includes Care Plan Updated component when appropriate to a Change in Condition/event 1/10/2013** **The facility is starting to change over to a new care plan form, which will readily identify added revisions to Care Plan. The DNS is responsible for training staff in the appropriate use of care plans. Staff in-service to be held on 2/14/2013.**	
R145 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the Registered Nurse (RN) failed to assure that each resident's plan of care addressed the assessed needs for 1 of 2 applicable residents. (Resident #1) Findings include: 1. Per review of Resident #1's record on 01/09/13, Resident #1 was admitted on 12/05/11 with a diagnoses that include dementia. Per a physician order dated 12/14/12 states "per VNA PT (physical therapy) exercise to be done daily any shift". Per review of the care plan dated 01/12/12 & 12/04/12 there are no instructions for the exercises to be done daily. Per a progress note from PT dated 12/30/11 states "continue with ambulation to and from bathroom and meals, and to assist with the exercise program as client will allow". Per the LNA ADL (activity of daily living) book states 'walk in hall every day,'	R145		

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R145	Continued From page 1 however there is no mention of the PT exercises. Per interview on 01/09/13 at 3:30 P.M. the staff nurse confirmed that the care plans do not address the need for daily PT exercises. Also see R-149	R145	**Care plans will be reviewed when there is a change in condition and care warrants and will be reviewed at least monthly for quality assurance during the nursing monthly summary process. 2/28/2013**	
R147 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (4) Maintain a current list for review by staff and physician of all residents' medications. The list shall include: resident's name; medications; date medication ordered; dosage and frequency of administration; and likely side effects to monitor; This REQUIREMENT is not met as evidenced by: Based on record review and interview, the RN (Registered Nurse) failed to assure that the current medication list/orders for 1 of 2 applicable residents (Resident #1) included the likely side effects to monitor for that are accurate and in agreement with physician orders. Findings include: 1. Per record review on 01/09/13, orders on the MAR (Medication Administration Record) and physician orders following an office visit for Resident #1 were not consistent. Resident #1 has a diagnosis of dementia with delusions and recent behavior changes. The physician wrote an order on 12/05/12 to "increase Mirtazapine to 30 mg. at h.s. [bedtime] and to observe/monitor suspiciousness". The evening nurse wrote on the MAR "sleepiness". Per review the Drug	R147	**Nursing will request the Physical Therapist, upon discharging a resident from their care to provide specific parameters and guidelines for their discharge orders. Requirements will be part of the Treatment Administration Record and LNA Flow sheets when appropriate.** 02/28/13 POC R-147 accepted 2/7/13 Susan D. Emmons RN **Action for R145 1. PCP order to discontinue daily exercises per VNA order 1/18/2013** **R147** **A new 24 Hour Report of Resident Change in Condition form is being utilized which includes a grid for Change in Condition, Narrative, Event Reporting and Follow-up. The Director of Nursing is responsible to audit the 24 Hour Change Report to the resident records and follow-up on the accountability of nursing overview, administration of medication, and nursing care. Follow-up includes New or Changed Order component for audit by the Director**	

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R147	Continued From page 2 Information Handbook for Nursing ; Lexi-Comp's 8th edition; pg 829 states under warnings/precautions for this drug as; 'all patients must be monitored closely for clinical worsening, suicidality or unusual changes in behavior' and 'may worsen psychosis'. During interview on 01/09/13 the day nurse stated that "it looks like the order says suspiciousness but I'll check with the doctor, not sure why the evening nurse wrote that". Per Interview that day, the DNS stated that they will contact the doctor to clarify the order. On 01/11/13 at 12:35 P.M. the DNS (Director of Nursing Services) confirmed that the order was inaccurately transcribed by the evening nurse to the MAR and will be corrected.	R147	**of Nursing to assure resident's name, the medication, dates, dosage and frequency of administration and side effects to monitor are noted properly in the MAR. DNS is responsible to counsel specific nurse staff on any discrepancies found during the audit process.** **1/11/2013** **Nursing In-service to be held to include proper review and verification of orders process. 2/14/13** **Granite Pharmacy will provide Pharmacy Consult services to OLP on a quarterly basis. 3/15/13** **OLP will schedule a Medication Administration and Pass audit and review by Granite Pharmacy.3/15/13**	
R149 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (6) Maintain a current list of all treatments for each resident that shall include: the name, date treatment ordered, treatment and frequency prescribed and documentation to reflect that treatment was carried out; This REQUIREMENT is not met as evidenced by: Per record review, observation and interview the residence failed to maintain a current list of all treatments, and documentation to reflect that treatment was carried out for 1 of 2 residents. (Resident #1) Findings include: 1. Per review of Resident #1's record on 01/09/13 Resident #1 was admitted on 12/05/11 with a diagnosis that includes dementia. Per a physician order dated 12/14/12 "per VNA PT	R149	POC R-147 Accepted 2/7/13 Susan L Simmons RN **R149** **Treatments have been separated to Treatment Administration Record sheet by the Pharmacy effective with the MARS and TARS for 2/1/13. All Physician Order Medication and Treatment s were reviewed by nursing personnel between 1/25/13 to 2/1/13. The DNS is responsible to review that documentation of treatments is being recorded and will audit**	

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R149	Continued From page 3 (physical therapy) exercise to be done daily any shift". Per review of the MAR [medication administration record] there is no documentation that the PT exercises were provided for the months of November and December 2012 and January 2013. Per interview on 01/09/13 at 3:30 P.M. the staff nurse confirmed that there is no documentation to reflect that the PT exercise was carried out. Also see R-145	R149	as part of the chart audit being conducted. 3/31/13 POC R149 accepted 2/7/13 Sharon L. Emmons RN R151 A new 24 Hour Report of Resident Change in Condition form is being utilized which includes a grid for Change in Condition, Narrative, Event Reporting and Follow-up. The Director of Nursing is responsible to audit the 24 Hour Change Report to the resident records and follow-up on the accountability of nursing overview, administration of medication, and nursing care. Follow-up includes Change in Condition categories for additional Event Reporting. Falls are one of the categories. DNS is responsible to counsel specific nurse staff on any discrepancies found during the audit process, to assure policy and procedures are followed. Nursing staff in-service 2/14/13 will include review of the Neurological and vital sign monitoring. All records will be made part of the permanent resident medical record. POC R-151 accepted 2/7/13 Sharon L. Emmons RN	
R151 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (8) Ensure that the resident's record documents any changes in a resident's condition; This REQUIREMENT is not met as evidenced by: Based on record review and interview, the RCH failed to ensure that the record of Resident #1 contained follow up documentation regarding a potential change in condition. Findings include: 1. Per record review on 01/09/13, Resident #1 was identified in a progress note on 09/14/12 as having sustained a head injury resulting from a fall. The note states Resident #1 "fell backward upon standing, disorientated to time and place, bleeding and complaining of pain, came back from [hospital] at 6 P.M.". There were no vital/neuro signs taken upon returning on 09/14/12 during the evening shift nor night shift. Vital signs were taken on 09/15/12 only on the 11-7 & 7-3 shifts and on 09/16/12 on the 7-3 shift.	R151		

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R151	Continued From page 4 Per interview on 01/09/13 at 3:30 P.M. the DNS stated "we usually have a neuro/vital sign sheet and its our policy to do them and I remember telling staff to do them for about 48 hours but I am not sure were they put them". There is no consistent neurological monitoring or vital sign documentation regarding a potential change in condition. This was confirmed by the DNS at this time.	R151	R206 **In-service to all staff on Abuse Neglect and Exploitation will be repeated and will include the use of the ADP Awareness Handbook.** **Department Managers will be directed when an employee comes to them verbally to report to have the individual fill out the ADP reporting form as part of our record. The Department Manager is to immediately notify the Administrator of any alleged abuse, for reporting to the licensing agency and provide the Administrator with the completed document. The Department Manager will report the abuse to ADP. The facility may conduct their own internal investigation but understands the responsibility to determine if the alleged incident did occur or not: that is the responsibility of the licensing agency. 02/14/13**	
R206 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.18 Reporting of Abuse, Neglect or Exploitation 5.18.a The licensee and staff shall report any case of suspected abuse, neglect or exploitation to the Adult Protective Services (APS) as required by 33 V.S.A. §6903. APS may be contacted by calling toll-free 1-800-564-1612. Reports must be made to APS within 48 hours of learning of the suspected, reported or alleged incident. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the RCH failed to assure staff report any case of suspected abuse to the Adult Protective Services (APS) required by 33 V.S.A.6003 within 48 hours of suspected abuse toward 2 of 2 residents reviewed (Resident #1 and Resident #2) Finding Include; 1. Per review of a report received at the Division of Licensing and Protection (DLP) on 09/27/12 noted that a LNA (licensed nursing assistant) reported an incident of 09/23/12, 4 days after an alleged abuse of Resident #1. Per interview on	R206	POC R-206 accepted 2/7/13 Sharon D. Emmons RN	

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R206	Continued From page 5 01/09/13 at 10:15 A.M. P.M. the Director of Nursing (DNS) stated that s/he was made aware of an incident that occurred on 09/23/12 between a staff person (LNA/nurse) and Resident #1 on 09/24/12. The DNS stated that s/he did an internal investigation but "didn't report it to DLP because I didn't think it was abuse". In addition, upon review of the the LNA/nurse's personnel file, there was another report on 09/24/12 regarding LNA/nurse yelling at Resident #2. Per a note to the Nursing Board from the DNS on 10/05/12 states "it now stands that there have been two reports of (LNA/nurse) reacting to difficult behaviors by applying physical force that may not be warranted and verbalizing frustration in an unprofessional manner." The DNS stated at this time s/he heard that a staff person reported the 09/23/12 incident to APS, involving Resident #1, and stated "I reported the 09/24/12 incident, involving #2, to the Nursing Board". The DNS expressed 'confusion to report what to who'. Per review of the policy and procedures for reporting states that "Reports must be made to APS within 48 hours of learning of the suspected, reported or alleged incident". Per interview at 12:00 P.M. the Administrator was not aware of the incident on 09/24/12 involving Resident #2 but was aware of the 09/23/12 incident, involving Resident #1. The Administrator confirmed that the RCH failed to report within 48 hours, incidents of alleged abuse to APS.	R206		
R213 SS=D	VI. RESIDENTS' RIGHTS 6.1 Every resident shall be treated with consideration, respect and full recognition of the	R213		

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R213	Continued From page 6 resident's dignity, individuality, and privacy. A home may not ask a resident to waive the resident's rights. This REQUIREMENT is not met as evidenced by: Based on interviews, 1 of 2 residents were not treated with respect and full recognition of their individuality. (Resident #2) Findings include the following: 1. Per record review on 01/09/13 Resident #2 was not treated in a respectful manner and full recognition of the resident's individuality. Per record review Resident #2, who was admitted on 8/14/12 is assessed as having poor safety awareness, is a total assist with ADLs, is non-verbal, has difficulty following simple commands and needs one person to speak at a time, as [resident] will get overwhelmed. Per review of the personnel file for a Nurse/LNA, an internal report showed staff expressed concern about the manner in which the Resident was treated on 09/24/12. The incident stated that the Nurse/LNA was attempting to administer medication while resident #2 was in the bathroom getting dressed. The Nurse/LNA "roughly attempted to put the pills into the mouth but the resident spit out the pills. The [Nurse/LNA] swore using foul language." Per a note to the Nursing Board from the DNS on 10/05/12 states "it now stands that there have been two reports of (LNA/nurse) reacting to difficult behaviors by applying physical force that may not be warranted and verbalizing frustration in an unprofessional manner." Per interview on 01/09/13 at 12:33 P.M. the Nurse/LNA stated "I was showing [resident] the	R213	R213 **Resident Rights** **Resident Rights In-service was completed on 12/20/2012 and nurse was in attendance.** **DNS counseled individual on 10/3/2012.** **Dealing with Difficult Behaviors In-service 10/25/12 was not attended by this individual. In-service on Dealing with Difficult behaviors will be completed by this individual 02/14/13** **Facility has ordered the CMS Hand to Hand program for dealing with those with Dementia, as well as, requested from the VHCA the OASIS program. Health Services Coordinator will review the programs with the DNS and implement programs to strengthen staff skill sets in dealing with dementia and difficult behaviors. 4/15/13** POC R-213 accepted 2/7/13 [illegible], RN	

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R213	Continued From page 7 meds to give and [another LNA] was providing care and the pills were spitted out and I had to get more meds but I didn't swear". The Nurse/LNA was unable to answer why the medication administration could not wait until after care was provided and was not aware of the care plan not to overwhelm the resident by having only one person speak at a time. S/he confirmed that the situation could've been overwhelming to the resident. The DNS confirmed at 3:30 P.M. that the Nurse/LNA did not recognize the resident's ability/individuality nor treated in a respectful manner but had since that time been educated on how to effectively interact with residents with dementia or limitations.	R213		